Your summary of benefits

Anthem®

Anthem® Blue Cross and Blue Shield

Your 2023 Contract Code: 6VDP

Your Plan: CSP Blue Open Access POS 1500/0%/3500

Your Network: Blue Open Access POS

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. Unless stated otherwise, the limitations for in- and out-of-network services are combined and services received in an office, Ambulatory Surgical Center, or outpatient facility are combined across all outpatient settings. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$1,500 person / $3,000 family	$4,500 person / $13,500 family
Overall Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of the year.*	$3,500 person / $7,000 family	$10,500 person / $31,500 family
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per member deductible and per member out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per member deductible or per member out-of-pocket limit. *In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.* *Your copays, coinsurance and deductible count toward your out-of-pocket limit. However, member cost sharing for Non-Network Human Organ and Tissue Transplant services do not apply toward the out-of-pocket limit.*		
Doctor Visits (virtual and office) *You are encouraged to select a Primary Care Physician (PCP).*		
Medical Chats and Virtual Visits for Primary Care *from our Online Provider K Health, through its affiliated Provider groups are covered at No charge.*		
Virtual Visits from online provider LiveHealth Online *for urgent/acute medical and mental health and substance abuse care via www.livehealthonline.com are covered at No charge.*		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Primary Care (PCP) and Mental Health and Substance Abuse Care *virtual and office*	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Specialist Care *virtual and office*	$70 copay per visit deductible does not apply	50% coinsurance after deductible is met
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Retail Health Clinic	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Manipulation Therapy	Not covered	Not covered
Acupuncture	Not covered	Not covered
Other Services in an Office		
Allergy Testing	$70 copay per visit deductible does not apply‡	50% coinsurance after deductible is met
Prescription Drugs - Dispensed in the office *For the drugs itself dispensed in the office through infusion/injection.*	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Surgery	$70 copay per visit deductible does not apply‡	50% coinsurance after deductible is met
Preventive care/screenings/immunizations *In-network preventive care is not subject to deductible, if your plan has a deductible. Non-Network preventive care services for children prior to their 6th birthday have no deductible.*	No charge	30% coinsurance after deductible is met
Preventive care for Chronic Conditions *per IRS guidelines*	No charge	30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services		
Lab		
Office	$70 copay per visit deductible does not apply‡	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	50% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray		
Office	$70 copay per visit deductible does not apply‡	50% coinsurance after deductible is met
Freestanding Radiology Center	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging - for example: MRI, PET and CAT scans		
Office	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	$300 copay per service deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care (Office Setting)	$75 copay per visit deductible does not apply	50% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	$350 copay per visit after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	0% coinsurance after deductible is met	Covered as In-Network
Emergency Room Mental Health and Substance Abuse Doctor Services	$30 copay per visit after deductible is met	Covered as In-Network
Ambulance (Air and Ground)	0% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Abuse Care at a Facility		
Facility Fees	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Surgery		
Facility Fees		
Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Ambulatory Surgical Center	$350 copay per visit deductible does not apply	50% coinsurance after deductible is met
Doctor and Other Services		
Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Ambulatory Surgical Center	0% coinsurance deductible does not apply	50% coinsurance after deductible is met
Hospital Stay (all Inpatient stays including Maternity, Mental Health and Substance Abuse)		
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 60 days combined per year.*	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Physician and other services including surgeon fees	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Home Health Care *Coverage is limited to 120 visits per year. Benefit limit and cost share applies to physical, occupational, speech, respiratory, cardiac and pulmonary therapy when performed as part of Home Health.*	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy) *Coverage for physical therapy and occupational therapy is limited to 20 visits combined per year. Coverage for speech therapy is limited to 20 visits per year.*		
Office	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Habilitation services (for example, physical/speech/occupational therapy) *Coverage for physical therapy and occupational therapy is limited to 20 visits combined per year. Coverage for speech therapy is limited to 20 visits per year.*		
Office	$30 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Pulmonary rehabilitation		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Office	$70 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation		
Office	$70 copay per visit deductible does not apply	50% coinsurance after deductible is met
Outpatient Hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis office and outpatient hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Radiation/Chemotherapy/Non Preventive Infusion & Injection office and outpatient hospital	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage for Inpatient Rehabilitation and Skilled Nursing services is limited to 60 days combined per year.*	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment per year.*	0% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable
Pharmacy Out of Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Prescription Drug Coverage **Network:** ***Advantage Network*** **Drug List:** ***Essential*** *Drugs not included on the Essential drug list will not be covered.*		
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (cost shares noted below)* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below) Maintenance medications are available through CarelonRx Mail (IngenioRx will become CarelonRx on January 1, 2023). You will need to call us on the number on your ID card to sign up when you first use the service.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy or an In-Network Pharmacy that carries your specialty drug.*		
Tier 1a - Typically Lower Cost Generic *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.*	$5 copay per prescription (retail) and $13 copay per prescription (home delivery)	50% coinsurance (retail only)
Tier 1b - Typically Generic *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.*	$20 copay per prescription (retail) and $50 copay per prescription (home delivery)	50% coinsurance (retail only)
Tier 2 - Typically Preferred Brand *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.*	$50 copay per prescription (retail) and $150 copay per prescription (home delivery)	50% coinsurance (retail only)
Tier 3 - Typically Non-Preferred Brand *Each 90 day supply script filled at Retail 90 pharmacies is subject to 3 times the 30 day supply cost share(s) charged at In-Network Retail Pharmacies.*	$85 copay per prescription (retail) and $255 copay per prescription (home delivery)	50% coinsurance (retail only)

Covered Prescription Drug Benefits	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Tier 4 - Typically Specialty (brand and generic)	20% coinsurance (retail and home delivery)	50% coinsurance (retail only)

Your plan also includes the following Healthy Support & Rewards features. *To see your rewards and additional information log into the Anthem website at anthem.com or call the customer service number on your member ID card.*		
Smart Rewards (Wellbeing Solutions Engagement Package 200)	Subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim.	Up to $200 per member per year

Notes:

- For additional information on this plan, please visit www.sbc.anthem.com to obtain a "Summary of Benefits and Coverage".
- If services are rendered by a non-participating provider and your plan includes out of network benefits, you may be responsible for any difference between the covered plan payment and the actual non-participating provider's charge.
- ‡ Your cost share will be reduced when services are provided in a PCP's office.
- Human Organ and Tissues Transplants require precertification and are covered as any other service in your summary of benefits.
- Physical Therapy: Athletic Trainers are covered by mandate for out-of-network only since athletic trainers are not contracted nor credentialed, therefore are not "in-network".
- This health plan includes an Employee Assistance Program (EAP) to support your emotional health and wellness with work life resources including one-on-one counseling by phone, in person and online, virtual visits through LiveHealth Online. Three visits are provided at no charge and 24/7, 365 days of support on the go.

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (844) 230-3683

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

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Language Access Services:

Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bina'idiłkidgo ná bohónéedzą dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí łą' bich'į' hadeesdzih ninízingo kojį' hodíilnih (844) 230-3683.

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